Integrated Care Value Case

Programme of All-Inclusive Care for the Elderly (PACE), USA




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This Value Case has been commissioned by the Local Government Association with support from the national partners on the integrated care and support collaborative

Local Government Association · directors of adass adult social services · Department of Health · NHS England · Public Health England · scie · Monitor Making the health sector work for patients · think local act personal · NHS Improving Quality

Produced by integrating care

About this Value Case

- The LGA, with support from the national integrated care partners, has commissioned the development of a toolkit to provide practical support for members of Health and Wellbeing Boards to highlight and promote the evidence of what makes the biggest difference to patient and service user experience as well as making better use of resources across the system.
- There are six key elements to the toolkit:
  1. An overarching ‘Value Case' for integrated care
  2. ‘Value case' summaries
  3. An evidence review of existing knowledge on outcomes of integrated care
  4. A model for local areas to map the impact of integrated care on outcomes, cost, activity and individual journey through the system
  5. A searchable database of integrated care initiatives throughout the country
  6. A signposting tool which will point to existing useful sources around the planning and implementation of integrated care
- This Value Case is part of a set of value cases which will show how local areas are delivering whole system integrated care, and the resulting impact this has had
- We are inviting all innovative areas who have delivered integrated care to come forward and develop their own Value Case to share with other local areas. For more information or to get involved please visit http://bit.ly/19ofToY

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Guiding principles for the value case:

The overall goal of this work is to develop value cases which are:

- Aimed at Health & Wellbeing Boards

And incorporate:

- Service user stories, capturing changes to the service user's journey.
- Features of the model, including enablers (e.g. technology initiatives to support the model)
- Costs of the model
- Evidence of benefit, including to activity, spend and outcomes.

We recognise that the information contained in the value case may prompt further questions, in which case we recommend you use the contact details at the end of the value case to follow up with a direct contact.

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About PACE

- Developed more than 30 years ago, PACE is a managed care programme in the US for frail elderly persons who meet state nursing home requirement criteria
- PACE receives capitated funding from both Medicare and Medicaid and is responsible for all of its participants' health care needs, from primary to acute to long-term care
- The programme's objective is to enable individuals to continue living in the community for as long as possible
- This is achieved by offering a comprehensive set of medical, psychosocial, and long-term care services
- At the core of the programme is adult day care, augmented by home care and meals at home
- Services are fully integrated with primary care that is focused on the geriatric population
- Initially starting as one initiative in San Francisco, California, there are now 88 PACE programmes across 29 states

Integrated Service Delivery and Team Managed Care

Interdisciplinary Teams

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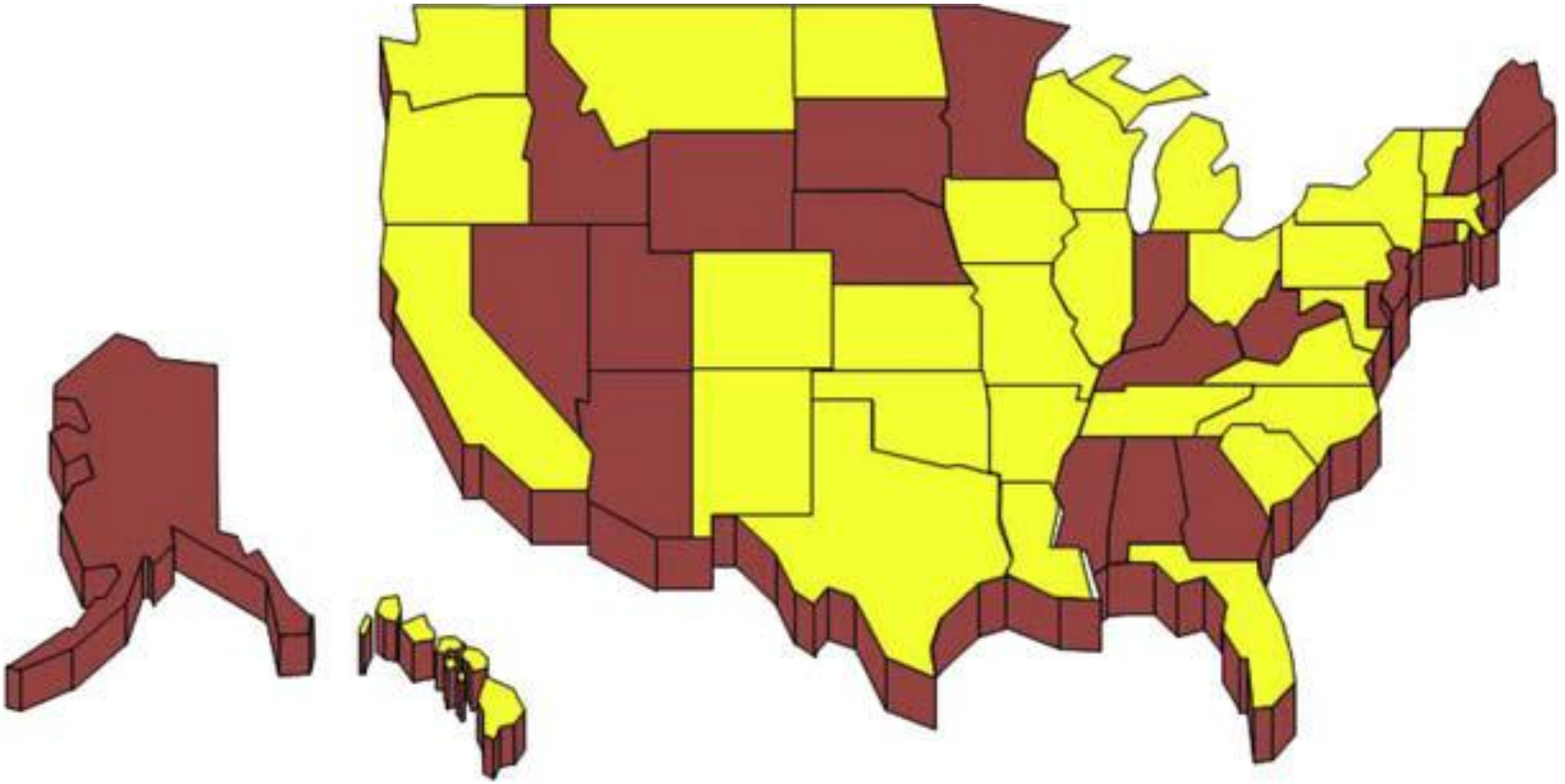
Where is PACE?



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PACE Visual Model

Set budgets

Federal Government

State government

Centres for Medicaid and Medicare (CMS)

Initial investment

- Consulting Fees: $100,000-420,000
- PACE Centre: $500,000-$2.3m
- Equipment: $130,000-$250,000
- Transportation: $0-$500,000
- Pre-operational staffing: $80,000-$540,000
- Enrollment: $500,000-$800,000
- Solvency Requirements: $200,000-$750,000

Total start-up investment:

- *High: $ 5.56 million*
- *Medium: $ 3.77 million*
- *Low: $ 1.51 million*

Set Targets

PACE Sponsors

Outcomes

Adult day care centre

- Ambulatory care (Preventative)
- Podiatry
- Recreational therapy
- Occupational therapy
- Dental care

Cost savings per capita

- **Enrollment in PACE $36,000 -** Average annual Medicaid payment per enrollee in 2007
- **Private Nursing $69,715 -** Average annual semiprivate room charge in FY 2008

Increased client satisfaction

Decreased mortality rates

Decreased hospital days

Decreased nursing home admissions

Increased job satisfaction

In the UK nursing homes cost an average of over £37,000 ($59,000) per capita p/a

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Applicability of the PACE model in the UK

Legal constraints

- The PACE model is based on pooled budgets and capitated funding
- A new funding model / flow whereby all benefits (DLA, AA and PIP) are paid directly to a UK 'PACE' organisation would be required in order to directly implement the US PACE model
- PACE is a provider-led model which requires full financial risk to be assumed
- It is a legal requirement for the provider to be a not-for-profit organisation
- A State Readiness Review is conducted for all potential PACE organisations

Workforce

- PACE workforce can be directly applied to that of the UK as the same roles exist
- PACE provides case management organised in day-care centres through multidisciplinary teams
- The team takes shared accountability for managing patients, providing services and promoting co-ordination and continuity of care to every individual – this is replicable in the UK
- PACE is available 24/7, 365 days a week

Information Sharing

- A data system facilitates the PACE model by collecting information on all aspects of a patient's health status; it also forms the basis of the patient's care plan
- This is in potential conflict with UK laws around information governance

Finance

- 90% of PACE enrolees are eligible for dual Medicare and Medicaid funding i.e. are from low-income background
- Participants who are dual Medicare and Medicaid eligible pay nothing towards the cost of their PACE care
- There are 10 million Americans who are dually eligible
- In the UK, nursing home care is mainly self-funded. Individuals receive free nursing home care only if their capital is less than £14,000

PACE is a non-bed based solution for frail elderly who require nursing-home level care. The use of pooled budgets, capitated funding, and particularly its workforce model all have direct applicability to localities in the UK.

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Outcomes evidenced by PACE: what difference does it make?

User experience

- Low disenrollment rates suggest patient satisfaction with service

Frontline staff experience

- Lower nursing assistant turnover rate of 30% compared to 58% for non-PACE programmes, suggesting higher staff satisfaction levels
- Increased job satisfaction compared to non-PACE employees
- Chance to form close relationships with patients
- Enjoy opportunities to discuss patients with other team members

Health & wellbeing outcomes

- Increase of 1.3 years life expectancy
- 45% increase in Quality of Life (QOL)
- 15% reduction in Activities of Daily Living (ADLs) limitations

Impact on institutional care

- 63% reduction in nurse visits after 18 months
- 52% reduction in inpatient days after 18 months
- 52% reduction in nursing home admission at 12 months
- 93% of enrolees in PACE are eligible for nursing home care but are able to continue to live outside of nursing homes as a result of the programme

Impact on cost

- Reduction of 5-15% over standard fee
- Costs for PACE enrolees are 16-38% lower than Medicare fee-for-service costs[1]

Productivity

- Less use of specialist physician care
- More appropriate prescription drug utilisation

"I can see how the changes I helped shape are starting to make a difference to my care."

" I can see who I need to see, mostly in my area."

[1]Traditional or "fee-for-service" Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country.

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How we did it: key enablers

Governance

- PACE programmes are run by sponsors, usually existing healthcare organisations
- During its first years of operation, a PACE programme may be subsidised by its sponsor when its enrolment is too low for revenues to cover expenses
- This allows the programme to stay afloat while growing to a breakeven point, usually at 100 enrolees
- A sponsored programme may benefit from the availability of resources at the parent organisation, such as access to a pool of home aides, marketing expertise, and name recognition if the sponsor has a good reputation in the community

Workforce development & OD

- Case management is run by a Multidisciplinary Team (MDT)
- MDT consists of a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist, dietician, PACE centre supervisor and a driver
- The PACE organisation must provide training to maintain and improve the skills and knowledge of each staff member with respect to the individual's specific duties

User & carer

- By acknowledging each participant's preferences for care, the MDT is responsible for determining care needs, allocating resources, coordinating all services, and evaluating outcomes for participants
- Several programmes have adapted to user feedback by providing more care at home

Finance

- Providers receive a capitated payment ranging between $1,624 to $4,706 per enrolee per month
- Providers assume full financial risk for all services including hospital and nursing home care, which should encourage emphasis on preventive care and rehabilitation
- Capitated payments are combined at the provider level, creating a flexible funding pool for all primary, acute and long term care services

"Pooled budgets and assumption of full financial risk ensures full accountability for the decisions we make"

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What we did: integrated care design

Users and carers

- The focus of every PACE organisation is to help enrolees live in the community for as long as possible
- Patient centred focus of all services
- Responsive to patients wants: including home care and meals at home where requested
- Patients regularly discuss and adapt care plan with MDT in a co-design approach

Adult day care centres

- Model for community-based programmes that integrate acute and long-term services and provide an alternative to nursing home care
- PACE enrolees attend an adult day care centre where they receive most services from a multidisciplinary team
- The care provided at the day centre covers the entire continuum of care and services to seniors with chronic care needs, allowing them to maintaining their independence in their homes for as long as possible

Medical care

- Provided by a PACE physician familiar with the history, needs and preferences of each participant

Single point of contact

- Users & staff have one contact point for all community & social care services

Preventative care

- Offers nursing; physical, occupational and recreational therapies; meals; and nutritional counselling as well as social work and personal care
- E.g. Routine eye tests to detect glaucoma and cataracts, at which point preventative interventions are used to delay further progression
- Diabetes care management has resulted in better Haemoglobin A1c control, fewer hospitalizations, fewer emergency room visits

"PACE did the impossible for my mother. I never thought she would be able to live with us again."

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Who we did it for and why

Users and Carers

- Provide better coordinated, joined up care to improve experience and clinical outcomes, so as to avoid premature institutionalisation
- Eligibility criteria:
    - Aged 55 or older
    - In need of nursing home care
    - Be able to live in the community with help from PACE
- There are 10million Americans who require long-term care, and demand is projected to grow substantially with an ageing population
- A trend away from institutionalisation, combined with a need to contain long term care costs led to the choice of this age group
- On Lok was the first model to successfully integrate the delivery of acute and long-term care services with successful results, leading to the development and expansion of PACE

Workforce

- Through the use of MDTs we empowered our workforce to provide the holistic care our participants required and wanted
- We did this because the spectrum of services available to patients and physicians was fragmented
- We wanted to make it easier to navigate and coordinate for the benefit of both our workforce and our clients
- Lack of recognition and the perception of not being listened to are recognised as factors causing job dissatisfaction

Federal government

- Federal government is generally supportive of the development of PACE programmes, recognising that programmes such as PACE have the ability to provide more, for less
- Desire to reduce costs of Medicare fee-for-services
- Medicaid pays 40% of total long term care expenditures
- Costs for PACE enrolees are 16-38% lower than Medicare fee-for-service costs for a frail elderly population and therefore have potential to fulfil federal government requirements

"I joined PACE to regain my dignity. I feel like I've done that"

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Lessons learned

Users and carers

- Not all individuals wanted to receive care at the day centre, we adapted our services so they could receive their care at home or visit the day centre as needed
- Some individuals wanted to retain relationship with their community physician rather than switch to a PACE physician. Adapted by offering ongoing access to community physicians and integrating those physicians into the MDT

Marketing

- Potential service users were unaware of our programme.
- Recognition that sufficient advertising budget is required in order to reach a wider audience
- Need to develop understanding of PACE by referring agencies and organizations; need to address any conflicts of interest that referring agencies might have (e.g. competitive long term care or care management lines of business)
- Need to address timeliness of approval by state agencies for enrolment in PACE

Top-down support

- Medicaid budget shortfalls have led some states to place enrolment caps at existing PACE sites
- This is a barrier to the growth and expansion of PACE programmes

For-profit providers

- For-profit providers currently operate under a limited pilot programme; uncertainty regarding future of the pilot and Medicare capitation rates has led to reluctance in moving forward
- Clarity over capitation rates could empower for-profit providers to enter the market

Unaffordable for middle income individuals

- Enrolees who are not eligible for Medicaid face out-of-pocket costs
- This deters many middle income individuals from enrolling in PACE
- One option moving forward is to arrange with long-term care insurers to classify PACE as a policy benefit; there are examples of this happening in the past though these are very limited

"We are working with state and PACE providers to overcome barriers recognised as preventing expansion of the programme"

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